PRINTED: 08/18/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVN2611AGC 01/27/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 327 RIVER FLOW DRIVE **RIVER FLOW MANOR 1 RENO. NV 89523** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 **Initial Comments** Y 000 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a bed increase survey conducted in your facility on 1/27/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was six. The facility submitted a request to increase their licensed beds from six to eight, but met the requirements for only seven beds. The following deficiencies were also identified: Y 271 Y 271 449.2175(2) Service of Food - Seating SS=D NAC 449.2175 2. Tables and chairs must be of proper height and of sufficient number to provide seating for the

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

number of residents authorized for the facility. They must be sturdy and have easily washable surfaces. Chairs must be constructed so that

they do not overturn easily.

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		(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
NVN2611AGC						01/27/2009	
DIVED ELOW MANOR 1			327 RIVER	T ADDRESS, CITY, STATE, ZIP CODE IVER FLOW DRIVE I, NV 89523			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETI DATE		COMPLETE
Y 271	Based on observation the facility's dining ro	ot met as evidenced by n and interview on 1/27 oom table did not allow for an increase from siz	7/09,	Y 271			
Y 355 SS=F	NAC 449.222 5. Provision must be bathrooms and toilet for use for more than This Regulation is n Based on observatio failed to ensure a proprovided for 3 of 3 re	ot met as evidenced by n on 1/27/09, the facility ovision for privacy was esidents who resided in I used the master bathro	: y the	Y 355			
Y 370 SS=G	NAC 449.224 1. Bedrooms must be provided for any members of the staff of a residential facility and their families who live at a residential facility. The bedrooms must comply with the provisions of subsections 2 to 8, inclusive, of NAC 449.218 and the provisions of NAC 449.220 and 449.221.		e of 18	Y 370			

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reported she would move her bed back into

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